Public Health-Seattle & King County
Quality Improvement Program

I. PURPOSE

The purpose of the Quality Improvement Program (hereafter referred to as the Program) is to continually improve the quality of our health care and other services, to outline the functions and activities of quality assurance and improvement, and to identify, control and reduce adverse health outcomes and medical malpractice events. In support of that purpose, the Program will:

1. Provide a coordinated framework for assessing, evaluating, and improving the quality of patient care and organizational functions.
2. Collect, maintain and analyze information pertinent to health care quality improvement.
3. Educate and assist health care providers to lead and participate in quality improvement activities and practice changes to support the Program purpose.

This Program focuses on patient satisfaction; involving staff at all levels of the organization; decision making that is supported by data and team knowledge; and working to continuously improve the quality of care and services.

II. QI PROGRAM ADMINISTRATION, AUTHORITY AND ACCOUNTABILITY

The Quality Improvement Committee (QI Committee) administers the Program. The QI Committee is appointed by the Leadership Group (LG) of Public Health, Seattle & King County (PHSKC), the governing body of this health care entity (see Appendix A). The QI Committee derives its authority from the Leadership Group and the Chief Operating Officer.
The ultimate accountability for quality improvement at PHSKC rests with the LG. In delegating responsibility for quality improvement activities, it is the LG's expectation that quality improvement activities will involve all levels of the organization acting collaboratively. The LG reviews reports from the QI Committee, as well as additional documentation generated

throughout the Department, requests further review or action as necessary, implements action plans and sets policy for the Department, and offers direction to the Committee during planning for Program activities.

III.QI COMMITTEE RESPONSIBILITIES

The Q I Committee provides guidance and direction to the Department to assess, design, monitor, evaluate and redesign process and service changes consistent with the goal of improving the quality of health care. The Committee is charged, by the LG, with the responsibility to implement and monitor system improvements to improve health care quality.

PHSKC will have a written annual QI Plan (See Appendix B, QI Plan) to identify and implement quality improvement measures consistent with the overall mission, goals and resources of the Department. This plan is based upon a calendar year and shall identify priorities for quality improvement activities. The plan will describe the primary functions, structure, focus and assigned responsibility for quality improvement activities. Creation, implementation and monitoring of the plan shall be the responsibility of the Quality Improvement Committee. The QI Committee has at a minimum, the following responsibilities:

1. Plan and Structure and of the Coordinated Quality Improvement Program

The Program includes three focus areas: systems and process, resource utilization, and risk management. Within each of these areas, quality improvement may consist of the following activities:

- Issue Identification and assessment
- Prioritization
- Process Improvement
- Ongoing monitoring

A. *Issue Identification and assessment*

Issues may be identified via a number of different data sources:

- Patient input

- Patient comment forms
- Quality assurance procedures
- Utilization review
- Incident reports
- Credentialing
- Provider peer review
- Cost accounting or productivity data
- Referral data
- Outcomes compared to community standards
- Satisfaction surveys from patients and clinicians
- Payor goals

Issues may be assessed by comparing process performance either internally over time and/or comparison with external standards. The measurable attributes of a process performance may be appropriateness, availability, timeliness, effectiveness, efficiency, safety, and respectfulness.

B. *Prioritization*

Once identified and assessed, improvement areas shall be prioritized in accordance with the mission, goals (see Appendix C) and resources of the Department.

C. *Process improvement*

Continual improvement of the processes involved in the delivery of health care service improves the overall quality of health care. Process improvement depends on cycles of problem solving steps:

1. Identifying, assessing and prioritizing a potential process improvement.
2. Organizing a team who knows and understands the process.
3. Use of good team dynamics and problem solving tools.
3. Planning the improvement.
4. Doing the improvement, continuing with data collection and analysis.
5. Checking the results and lessons learned.
6. Acting to institutionalize the gains from the improvement.

D. *Ongoing Monitoring*

Continual monitoring of system improvements assures that the goals of the Program are being met, and standards maintained. System improvement activities may be modified as indicated by assessing the effects of the improvement activity against the purpose of the Program and mission of the Department. Components of the Program are reviewed at least annually including, credentialing, safety, risk management, client complaints, and other areas identified.

2. PROGRAM OVERSIGHT AND COORDINATION

The QI Committee is responsible for oversight and coordination of the Program. The Committee maintains oversight to ensure that Program activities are consistent with the Program purpose. At its discretion, the Committee may delegate Program activities to sub-committees, employees and agents of the Department while retaining oversight responsibility.

3. QI COMMITTEE MEMBERSHIP

The QI Committee shall be comprised of individuals who broadly represent the health care services of the Department and who are in a position to effectively assess, evaluate, plan and implement strategies pertinent to patient care and organizational processes. The membership of the Committee shall represent all Divisions of the Department. Members will include the following services or job responsibilities:

Chair: Rotating

Administrative Services
Community Health Services
Director's Office
Emergency Medical Services
Environmental Health
Jail Health
Prevention Division
QI Coordinator (Staff support)
Risk Management

Other representatives as needed include but not limited to:

Credentials Specialist

Program Experts

Clinical Experts

Employee Health and Safety Coordinator

Medical Records Manager

4. QUALITY IMPROVEMENT COMMITTEE MEETINGS

Meetings shall be held quarterly or more often as needed at the discretion of the Committee. Meetings will be scheduled in advance for the calendar year, on a consistent day and time. Minutes will be kept of all meetings (see IV: Documentation).

5. QUALITY IMPROVEMENT COMMITTEE SUB-COMMITTEES

The QI Committee shall have the authority and responsibility to appoint sub-committees as necessary. All such sub-committees shall report directly to the QI Committee. Each Division and Personal Health Service Site will have a Quality Committee to plan and coordinate QI /QA activities within it's jurisdiction. At each division or *site*, multidisciplinary teams of providers and other staff will carry out these activities. For Personal Health Services, each site has an assigned *QI nurse* to facilitate QI/QA activities. Other QI sub committees include the following Committees: Department Safety; Credentials; Pharmacy and Therapeutics; and Jail QI Committee. Ad Hoc subcommittees can be formed to work on specific issues identified by and authorized by the QI Committee.

6. CONFIDENTIALITY

Members, participants, and visitors of the QI Committee shall sign an agreement of confidentiality (see Appendix E) relevant to the functions of the Program and its activities. All employees working with QI issues are asked to sign the confidentiality form. All employees are responsible for quality practice or service, and therefore shall be asked to sign a confidentiality form upon employment.

7. SERVICE REVIEWS

Retrospective, prospective, or concurrent review of services will be done to measure key characteristics such as effectiveness, accuracy, timeliness and cost. Retrospective and prospective review of services will be accomplished by:

- review of incident report forms (see Appendix F)
- monitoring the provision of preventive health care
- clinician peer review
- patient satisfaction surveys (Appendix G)
- outcomes research
- review of client complaints
- review client comment forms
- contract review data from health care payors

Both current and future services will be reviewed to ensure the service provides quality patient care in a cost-effective manner that improves health care outcomes.

8. QI INFORMATION

Using the data sources noted in sections 1 and 7 above, the Committee will collect, maintain, analyze and review data to:

- recommend further analysis or study;
- recommend revision of Department policy and/or procedure
- recommend training and/or education of clinicians and staff; or
- delegate improvement to appropriate subcommittees.

9. REPORTING TO GOVERNING BODY

The Committee reports at least semi-annually on Program activities and actions to the LG. An annual written report shall be submitted by the Committee to the LG, the Governing Body, which includes a report of quality improvement activities, actions, outcomes, trending of clinical and service indicators and other information pertinent to the purpose of the QI Committee. Reports will be made more often as needed. An annual summary of Program activities and actions shall be made available to the governing body and other interested parties. Any reports to LG or interested parties will comply with the same standards of confidentiality as maintained

for patient medical records and provider files, with patient and provider identifiers removed to protect privacy. The LG has the authority to modify and redirect the Committee activities if it deems necessary. Communication may be written or oral. The LG gives feedback to the QI Committee Chair, who takes it back to the Committee.

10. EXTERNAL REPORTING REQUIREMENTS

The Committee will respond to any reporting requirements to appropriate state, local or federal authorities or payors. When documents are requested, a written authority for release from Risk Management and the Chair of the QI Committee must be completed. Items to be reported include professional misconduct, malpractice payments to patients and other items required by law.

IV. QUALITY IMPROVEMENT PROGRAM DOCUMENTATION

Minutes shall be recorded at all meetings of the QI Committee and at any appointed sub-committees. Any quality improvement studies, recommendations of studies, incident reports, provider reviews, and other recorded information pertinent to the QI Program shall be attached or incorporated by reference into the QI Committee minutes. It is the intent of the QI Committee that any Program documentation shall be protected from legal discovery to the fullest extent allowed by law. Minutes will be kept on disc or paper in a locked cabinet.

The QI Committee minutes will be available for internal review by selected departmental professionals/ or departmental committees on a need to know basis as determined by the QI Committee. Summaries of the minutes with identifying names removed may be provided to health care payors, governmental or regulatory agencies or other entities at the sole discretion of the QI Committee. Such disclosure will only be made when the position of PHSKC in any future legal or regulatory proceeding is clearly known.

All QI Committee minutes, incident reports, provider reviews and all other recorded information pertinent to the QI Program shall be clearly marked "Quality Improvement Program, Confidential". This will be ensured by the QI Coordinator.

V. INFORMATION COLLECTION AND MAINTENANCE

The Committee shall continually collect and maintain information concerning:

1. *Experience with negative health care outcomes and injurious incidents*

Information on adverse health care outcomes and injurious incidents will be collected concurrently and maintained using incident/accident reporting, peer review, client complaint forms, chart reviews, and patient records of unexpected individual adverse health care outcomes.

2. *Professional liability premiums, settlements, awards, and costs for injury prevention, safety improvement and health care improvement activities.*

Information on professional liability premiums, settlements, awards and costs for injury prevention, safety improvements and health care improvement activities will be provided to the QI Committee by the PHSKC Administration Personnel.

3. *Safety improvements, health care system improvement activities and resource utilization.*

Information on safety improvements, health care system improvement activities and resource utilization will be provided to the QI Committee by the administration, employees, or agents of PHSKC using whatever external or internal data sources are deemed appropriate by the QI Committee. Patient complaint and grievance logs, completed at clinic sites, will be submitted to the QI Committee from each clinical site quarterly. Summary information shall be periodically provided to the governing body and the providers. The Complaint/Grievance Policy is further addressed in Section IX of this document.

VI. INCIDENT/ACCIDENT REPORTING

Accidents, injuries, negative health care outcomes and other information pertinent to health care quality improvement will be reported to the QI Committee as described in the Incident/ Accident Policy (see Appendix F). An incident/accident report form shall be used to ensure consistent reporting. Employee accident reports will be sent for review to the King County Safety Office as well as to the Department's Risk Management Office within three days of the incident/accident. Patient incident reports will be sent for review to the Department's Risk Manager who will route them to the appropriate professional chief.

Incidents and accidents are tracked and trended. The QI Committee will make recommendations including subcommittees when trends are noted. This ad hoc committee will meet to investigate and make recommendations. This ad hoc committee will report to the QIC as needed.

Maloccurrences that may result in adverse health outcomes or health care malpractice claims will be investigated either internally by the Department Risk Manager, to the extent feasible, or reported to the King County Risk Manager's office for appropriate investigation and resolution.

VII. QUALITY IMPROVEMENT EDUCATION

The QI Committee shall sponsor quality improvement educational activities PHSKC Staff at least annually or more often as necessary. Educational activities will be in addition to other continuing education activities provided or facilitated PHSKC. Educational activities may include, but are not limited to:

1. *Quality improvement in health care:*
   Education in health care quality improvement may be provided by the Quality Improvement Coordinator, staff, providers, employees, agents or consultants of the Department. The QI Committee shall be responsible for ensuring that quality improvement data and information is communicated to the clinicians and staff of the Department.
2. *Safety and injury prevention:*
   Safety and injury prevention, infection control or hazardous materials education is provided by the Employee Health and Safety Coordinator, or providers, employees, agents or consultants of the Department. Safety and injury prevention information is provided to all staff at the time of employment orientation, on an ad hoc basis and as a result of mandatory continuing education or activities that may be required by law or regulation.
3. *Responsibilities for reporting professional misconduct*
   Education on responsibilities for reporting professional misconduct may be provided by state and/or federal regulatory or enforcement agencies; or providers, employees, agents or consultants of the Department. This education is provided at the time of employment orientation or at anytime during employment.
4. *Legal aspects of providing health care*

Education on legal aspects of providing health care may be provided by the Department Risk Manager or the King County Prosecuting Attorney's office, at orientation or at anytime during employment. All clinicians will comply with State requirements for continuing education on risk management.

5. *Improving communication with patients*
   Education on effective communication to decrease risk of malpractice claims may be provided by clinicians, employees, agents or consultants of the Department; or the risk manager at the time of employment orientation or anytime during employment.
6. *Causes, prevention and reduction of malpractice claims*
   Education on the cause, prevention, and reduction of malpractice claims may be provided by the risk manager, at employment orientation or anytime during employment.

VIII. PROVIDER REVIEW

Public Health - Seattle & King County has an IHCP or *independent Health Care Practitioner* credentialing process resulting in a 2 year Clinical Staff Appointment term. This is based on the Credential Policy (see Appendix H). (IHCPs are MDs, Dentist, ARNPs and other licensed independent practitioners who, within the scope of their training, Licensure and experience, can independently diagnose, initiate, alter or terminate health care treatment.)

In addition to meeting current King County hiring practices, offers of employment to these professionals are contingent upon satisfactory completion of the credenialing process. Credentialing at PHSKC includes an application along with primary source verification of licensure. Documentation is collected on DEA registration, education, residency, board certification, or eligibility and other significant certification. Also included is a statement of mental and physical capacity and competence to deliver health care, and claims history.

As appropriate to the scope of the provider's practice, every IHCP provider employed or independently contracted by the Department shall have a recredentialing review every 2 years. This will include a statement of mental and physical capacity, competence to deliver health care, a review of verification of licensure, medical staff appointments, and other updates since the last clinical staff appointment 2 years prior.

The provider review process may include any of the following elements as deemed appropriate by the Quality Improvement Committee:

1. Patient satisfaction data
2. Review by peer providers within the same clinical focus / scope from throughout the Department as appropriate.
3. Reviews by support staff as appropriate
4. Verification of licensure
5. Verification of current medical staff appointments
6. Queries to the National Practitioner Data Bank
7. Evaluation of CE participation
8. Evaluation of risk management issues
9. Review of a representative sample of current charts
10. Productivity review
11. Utilization review
12. Completion of form verifying health status/ability to perform

Program information regarding a "provider" will be maintained within the Department's Individual Credential File (ICF) for that provider. (This may be nursing and other Allied Health Care Professionals in the Department.) Information on Allied Health Care staff will be kept in an Individual Professional File (IPF). All such information maintained on a provider pertinent to the QI Program shall be clearly marked as falling under the purview of the Program and shall be maintained with the same standards of confidentiality as patient medical records, with patient identifiers removed as appropriate to protect patient privacy.

IX. COMPLAINT RESOLUTION

The Program incorporates a procedure to investigate and resolve, in a timely fashion and to the extent feasible, patient complaints pertaining to accidents, injuries, treatment and other events that may result in adverse health outcomes or claims of health care malpractice. Complaints are resolved as close to the occurrence as possible. Patients have the ability to appeal decisions.

Records shall be kept of patient complaints and the response thereto (See Appendix I, Complaint Policy). These records shall come under the purview of the QI Program and are QI Program work product.